MRN: 01178378 Visit: 2103902219 Age: 33y (04/15/1988)	TEREZ, JAHREL Gender: Male	St Barnabas Hospital Current Location: Emergency Dept

ED - Re-Evaluation and Disposition (RED) [Charted Location: Emergency Dept] [Date of Service: 02-09-2021 02:58, Authored: 02-09-2021 02:58]- **for Visit: 2103902219**, *Incomplete, Entered, Signed in Full, Available to Patient*

RESPONSE TO TREATMENT/SUMMARY OF CARE:

Response to Therapy/ Observation/ Disposition: labs/images reviewed- anterior shoulder dislocation s/p reduction ; reports improvement since arrival

This patient has stable vital signs and harbors no emergency medical condition as determined by our focused medical screening exam directed by the chief complaint. Signs, symptoms, results were reviewed with patient. Pt agreed to return if symptoms return and/or worsen. STRICT return precautions given. Red Flags discussed with patient.

The patient understands the discharge and follow up instructions that we provided.

The patient is medically cleared for discharge.

MEDICAL DECISION MAKING:

Pertinent Results:

General Hematology:

02-09-2021 00:26, CBC W/ Differential

• WBC (10^3/uL).	↑ 10.3	[4.2 - 9.1 10*3/uL]
• RBC (10^6/uL).	5.28	[4.63 - 6.08 10*6/uL]
• Hgb (gm/dl).	14.7	[13.7 - 17.5 gm/dL]
• Hct (%)..	45.6	[40.1 - 51.0 %]
• MCV (f1).	86.4	[79.0 - 92.2 fL]
• MCH (pg).	27.8	[25.7 - 32.2 pg]
• MCHC (gm/dl).	↓ 32.2	[32.3 - 36.5 gm/dL]
• RDW (%).	13.9	[11.6 - 14.4 %]
• Platelet Count..	258	[163 - 337 10*3/uL]
• MPV (f1).	11.9	[9.4 - 12.4 fL]
• Neutrophil (%).	↑ 69.8	[34.0 - 67.9 %]
• Lymphocyte (%).	↓ 20.8	[21.8 - 53.1 %]
• Monocyte (%).	9.1	[5.3 - 12.2 %]
• Eosinophil (%).	↓ 0.0	[0.8 - 7.0 %]
• Basophil (%).	0.2	[0.2 - 1.2 %]
• Immature Granulocyte (%)..	0.1	[0.0 - 0.5 %]
• NRBC (/100 WB).	0.0	[0.0 - 0.2 /100{WBCs}]
• Neutrophil (10).	↑ 7.17	[1.78 - 5.38 10*3/uL]
• Lymphocyte (10).	2.14	[1.32 - 3.57 10*3/uL]
• Monocyte (10^3).	↑ 0.93	[0.30 - 0.82 10*3/uL]
• Eosinophil (10).	↓ 0.00	[0.04 - 0.54 10*3/uL]

• Basophil (10^3).	0.02	[0.01 - 0.08 10*3/uL]
• Immature Granulocyte (10^3).	0.01	[0.00 - 0.02 10*3/uL]

02-09-2021 00:26, Type And Screen

- Group. O
- Rh. NEG

General Radiology:

02-08-2021 20:57, XR Shoulder 2 Views Uni

- **XR Shoulder 2 Views Uni**

Referring Physician-
AYUM,ANNA

Patient Name- JAHREL TEREZ

History- Shoulder pain R R shoulder pain s/p assault by police
r/o dislocation
This is a final report
Images- 3

EXAM- R XR SHOULDER 2 VIEWS UNI

Date of Exam- 2021-02-08 21-12-23

Comparison exam- None provided

Findings-

Exam is POSITIVE for anterior dislocation right shoulder. No evidence of associated fracture. Right clavicle appears intact. Included right ribs are intact.

Impression-

Anterior dislocation right shoulder.
No associated fracture seen.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Lilian Cavin, MD

02/08/2021 21-40 EST

MRN: 01178378 Visit: 2103902219 Age: 33y (04/15/1988)	**TEREZ, JAHREL** **Gender: Male**	**St Barnabas Hospital** **Current Location:** **Emergency Dept**

M.D. Please call Imaging On Call 1.800 TELERAD (835.3723) with questions.

This report was electronically signed by-

Lillian Cavin MD

8th Feb, 2021 9-41-00PM EST
Transcriptionist- LILLIAN CAVIN, M.D.
Reading Physician- LILLIAN CAVIN, M.D.
Releasing Physician- LILLIAN CAVIN, M.D.
Released Date Time- 02/08/21 2144

2094^XR SHOULDER 2 VIEWS UNI^RAD 202720 LILLIAN CAVIN& M.D.&M.D. 202720 LILLIAN CAVIN& M.D.&M.D. 2094^XR SHOULDER 2 VIEWS UNI^RAD 202720

General Coagulation:

02-09-2021 00:26, PT/APTT

• PT (seconds).	9.8	[9.1 - 11.7 Seconds]
• INR (ratio).	0.9	[0.9 - 1.1 {ratio}]
• APTT.	27.4	[23.2 - 31.6 Seconds]

General Chemistry:

02-09-2021 00:26, Comprehensive Metabolic Panel

• Sodium.	139	[135 - 145 mEq/L]
• Potassium.	4.0	[3.5 - 5.3 mEq/L]
• Chloride.	106	[96 - 108 mEq/L]
• Carbon Dioxide.	24	[23 - 30 mEq/L]
• Glucose.	↑ 112	[70 - 99 mg/dL]
• Urea Nitrogen.	15	[8 - 23 mg/dL]
• Creatinine.	1.0	[0.6 - 1.2 mg/dL]
• Calcium.	9.6	[9.2 - 11.0 mg/dL]
• Albumin.	4.3	[3.8 - 5.0 gm/dL]
• Protein Total.	7.4	[6.0 - 8.0 gm/dL]
• ALT/SGPT.	26	[4 - 36 IU/L]
• AST/SGOT.	26	[8 - 33 IU/L]
• Bilirubin Total.	1.0	[0.1 - 1.2 mg/dL]
• Alkaline Phosphatase..	99	[38 - 126 IU/L]

• Anion Gap.	9	[7 - 16 mEq/L]

General Blood Bank:

02-09-2021 00:26, Type And Screen

• Antibody Screen.	NEG	

Electronic Signatures:

Tramutola, Amanda (DO/Resident) (Signed 02-09-2021 02:58)

Authored: *RESPONSE TO TREATMENT/SUMMARY OF CARE, MEDICAL DECISION MAKING*

Last Updated: *02-09-2021 02:58 by Tramutola, Amanda (DO/Resident)*

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Form Version: NYC-COMPT-BLA-PI1-D6

Personal Injury Claim Form

Electronically filed claims must be filed within 90 days of the occurrence using the Office of the NYC Comptroller's website. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period to preserve your rights.

I am filing: (•) On behalf of myself.
( ) On behalf of someone else. If on someone else's behalf, please provide the following information.

Last Name:	
First Name:	
Relationship to the claimant:	

Claimant Information

*Last Name:	Terez
*First Name:	Jahrel
*Address:	1881 Sedgwick Avenue
Address 2:	Apt 1B
*City:	Bronx
*State:	NEW YORK
*Zip Code:	10453
*Country:	USA
Date of Birth:	*Format: MM/DD/YYYY*
Soc. Sec. #	
HICN: (Medicare #)	
Date of Death:	*Format: MM/DD/YYYY*
Phone:	
*Email Address:	jahnyaniterez@gmail.com
*Retype Email Address:	jahnyaniterez@gmail.com
Occupation:	

City Employee? ( ) Yes ( ) No ( ) NA

Gender ( ) Male ( ) Female ( ) Other

( ) Attorney is filing.

Attorney Information (If claimant is represented by attorney)

Firm or Last Name:	
Firm or First Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	
Tax ID:	
Phone #:	
*Email Address:	
*Retype Email Address:	

The time and place where the claim arose

*Date of Incident:	02/08/2021 *Format: MM/DD/YYYY*
Time of Incident:	*Format: HH:MM AM/PM*
*Location of Incident:	1881 Sedgwick Avenue, Bronx, NY 10453 (outside in courtyard); precinct 46; St. Barnabas Hospital, 4422 3rd Ave, Bronx, NY 10457
Address:	
Address 2:	
City:	
*State:	NEW YORK
Borough:	

Denotes required fields. A Claimant OR an Attorney Email Address is required.

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

***Manner in which claim arose:**

Jahrel Terez ("Claimaint") saw two police officers outside of his apartment. Claimant went into the courtyard near his apartment to meet them. The smaller officer was about 5'7" or 5'8," 130 to 150 lbs, and had a crew cut. The other was heavier and taller; upon information and belief, his name was Kim Bouris. The officers told Claimant that he was under arrest. When Claimant asked what he was under arrest for, Officer Bouris told him to "stop resisting." Each officer took one of Claimant's arms and began to handcuff him as they pushed him to the ground. Officer Bouris dislocated Claimant's right arm and repeatedly punched him in the side. Officer Bouris put his leg on Claimant's neck while Claimant's coat was pulled over Claimant's head. When Claimant said that he could not breathe, Officer Bouris said "I don't care." The other officer continued to hold Claimant's left arm down throughout.

Two other police officers arrived. One of the newly arrived officers removed the coat from Claimant's head, and the original two officers let go of Claimant. Even though Claimant repeatedly told the officers that his arm had been dislocated and requested medical assistance, he remained handcuffed while being transported to the precinct; paramedics did not arrive until nearly four hours after his initial arrest. Then, despite his request to be transported without handcuffs due to his arm being dislocated, Claimant was transported to the hospital in handcuffs. The medical staff at the hospital needed three attempts to reset Claimant's arm because it had been out of socket for five hours. Claimant also suffered additional bodily injuries.

Claimant's claims include unlawful use of force, infliction of emotional distress, false imprisonment, false arrest, and all other applicable claims under federal and local laws as well as the New York State Constitution and the U.S. Constitution.

Client seeks compensatory damages arising from medical expenses, time wrongfully in jail, emotional and physical pain and suffering, violation of his constitutional rights, and all other applicable compensatory damages. Client also seeks punitive damages due to egregious nature of the government's misconduct.

** Denotes required field.*

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Medical Information

st Treatment Date:	02/08/2021 *Format: MM/DD/YYYY*
ospital/Name:	St. Barnabas
ddress:	4422 3rd Avenue
ddress 2:	
ity:	Bronx
tate:	NEW YORK
ip Code:	10457
ate Treated in mergency Room:	02/08/2021 *Format: MM/DD/YYYY*

as claimant taken to hospital by ambulance? ◉ Yes ○ No ○ NA

mployment Information (If claiming lost wages)

mployer's Name:	
ddress	
ddress 2:	
ity:	
tate:	
ip Code:	
ork Days Lost:	
mount Earned eekly:	

reating Physician Information

ast Name:	
irst Name:	
ddress:	
ddress 2:	
ity:	
tate:	
ip Code:	

Witness 1 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone:

Witness 2 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone:

Witness 3 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone:

Witness 4 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone:

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in

Last Name:
First Name:
Address
Address 2:
City:
State:
Zip Code:

Non-City vehicle driver

Last Name:
First Name:
Address
Address 2:
City:
State:
Zip Code:

Insurance Information

Insurance Company Name:
Address
Address 2:
City:
State:
Zip Code:
Policy #:
Phone #:

Non-City vehicle information

Make, Model, Year of Vehicle:
Plate #:
VIN #:

City vehicle information

Plate #:

Description of Claimant:

◯ Driver ◯ Passenger
◯ Pedestrian ◯ Bicyclist
◯ Motorcyclist ◯ Other

City Driver Last Name:
City Driver First Name:

Total Amount Claimed: $1,000,000.00 *Format: Do not include "$" or ",".*

*The **Total Amount Claimed** can only be entered once the following required fields are entered:*

Claimant Last Name
Claimant First Name
Claimant Address,City,State,Zip Code, and Country
Claimant Email or Attorney Email
Date of Incident
Location of Incident (including State)
Manner in which claim arose

I certify that all information contained in this notice is true and correct to the best of my knowledge and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties and civil liabilities.